PRINTED: 08/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G	<u></u>	08/0	2/2012
	ROVIDER OR SUPPLIER	PITAL LTCU	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC TAG CROSS-REFERENCED TO TH DEFICIENCY		JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F	000			
F 226 SS=C	Health Resurvey. 483.13(c) DEVELOP/ABUSE/NEGLECT, E The facility must developolicies and procedur mistreatment, neglect and misappropriation This REQUIREMENT by: The facility reported Based on record revie facility failed to incorp for Medicare and Medicare and Medicare and Medicare in a Long-Term Section 1150B of the existing facility policy. Findings included: - The undated facility Neglect" lacked inform suspicion of crimes by least one law enforce.	elop and implement written res that prohibit t, and abuse of residents of resident property. T is not met as evidenced a census of 25 residents. ew and staff interview, the porate the 6/17/11 Centers dicaid Services (CMS) letter reasonable Suspicion of a care Facility (LTC): Social Security Act" into the	F	226			
LABORATORY	survey agency by a c suspicion of serious be others within 24 hours include that the facilit individuals annually of to prevent retaliation report, and post infor- rights, including the ri				TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING			
		17E294	B. WIN	G		08/02	2/2012
	OVIDER OR SUPPLIER ON COUNTY MEM HOSP	PITAL LTCU		40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253 SS=E	who filed a report. An interview on 7/31/ administrative nursing policy/procedure on A include all the require letter. The facility failed to fund procedures that procedures that proglect and abuse of misappropriation of p 483.15(h)(2) HOUSE MAINTENANCE SERTHE facility must proving maintenance services sanitary, orderly, and This REQUIREMENT by: The facility identified Based on observation interview the facility fand comfortable interdays on site. Findings included:	retaliated against anyone 12 at 2:14 P.M. with g staff B agreed the facility Abuse and Neglect did not ed information in the CMS ully develop written policies prohibit mistreatment, residents and roperty. KEEPING & RVICES vide housekeeping and a necessary to maintain a comfortable interior. T is not met as evidenced a census of 25 residents. n, record review, and staff ailed to maintain a sanitary ior of the facility for 2 of 4		226			
	one on 7/25/12 from 9 from 7:00 A.M. to 10; environmental tour or	g the initial tour and stage 9:00 to 5:00 P.M. on 7/26/12 30 A.M. and during n 7/26/12 from approximately M., revealed the following:					
			1		1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	IG_		08/0	2/2012
	OVIDER OR SUPPLIER ON COUNTY MEM HOSP	ITAL LTCU	_	4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253	rooms, resident bather room Hall C: * chipped and loose of and resident bathroom Hall D: * chipped floor tiles the room * wall plaster/paint per room Living Area: * a brown high backed with 2 inch tan masking seam for approximate tape was peeled at the halls. An interview on 7/26/P.M. with maintenance things up as they need written plan of improve They just finished rem room on Hall C and on 7/23/12. He/she said remodel Hall B bathing were no plans to remove rooms on Hall D becar resided on that hall. It residents did use Hall during the bath/toileting the said remodel that the late of the part of the p	les on the floors in resident coms and in the bathing floor tiles in resident rooms are bathing room and toilet eled in the bathing and toilet eled in the bathing and toilet d vinyl/leather covered chair ag tape on the back/side by 18 inches. The masking etop of the seam. The hallway between A and 12 at approximately 2:30 estaff H said they fixed ded, but did not have a ement for maintenance. The hodeling the bathing/toileting pened it up Monday, they next planned to groom. He/she said there are bodel the bathing/toileting use residents no longer Maintenance staff H said the D bathing/toileting rooms are groom remodel on Hall C. se/chipped floor tiles during	F	253			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER DN COUNTY MEM HOSP	ITAL LTCU	•	40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 253	preventive routine maspecific areas for roupolicy note for mainted orders submitted by senvironmental rounds. A phone interview on staff H at 3:30 p.m. secommittee made mon He/she said they iden floor areas, jagged and chipped and loose flootaff fixed the areas of the the said he/she with missed the areas of comaintenance staff H of the facility failed to promaintenance services comfortable manner facility. 483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COM	dure dated 11/8/11 for intenance failed to note tine maintenance. The nance staff to check work taff members daily and do monthly. 8/1/12 with maintenance aid members of the safety thly environmental rounds. It fied such things as uneven despinated wood and for tiles, then maintenance never identified as they could. The as not sure how they concern revealed to the environmental tour. Tovide housekeeping and the in a sanitary and for the residents in the control of the assessment design and the revise the resident's of care. The provide housekeeping and the in a sanitary and for the residents in the control of the assessment design are the resident's of care. The provide housekeeping and the resident's of care are at that includes measurable to bles to meet a resident's mental and psychosocial ed in the comprehensive describe the services that are		253			
	to be furnished to atta	in or maintain the resident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING		(X3) DATE SURVEY COMPLETED	
		17E294	B. WING	G	08	/02/2012	
	ROVIDER OR SUPPLIER	PITAL LTCU	•	STREET ADDRESS, CITY, STATE, ZIP CO 408 DELAWARE STREET WINCHESTER, KS 66097	•		
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -			PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	§483.25; and any se be required under §4 due to the resident's §483.10, including the under §483.10 (b)(4). This REQUIREMEN' by: The facility reported and the sample was record review, and stailed to develop con (#30, #15) residents Findings included: Resident #30's 7/1 Data Set 3.0 recorded depression, inattentic physical behavioral so others, wandered, an needed extensive as mobility/transfer/dresmonths prior to admi The Care Area Asse falls recorded the resident general, had no falls to adjust position in the second control of the second control of the recorded the resident general, had no falls to adjust position in the second control of the se	hysical, mental, and ing as required under rvices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment T is not met as evidenced a census of 25 residents 12. Based on observation, taff interview, the facility inprehensive care plans for 2 of the sample. 3/12 admission Minimum and the resident had mild on, disorganized thinking, symptoms directed toward and intruded on others, sistance with bed esing/toileting, a fall 2-6 ssion, and had no restraints.	F 2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/02/2012	
	OVIDER OR SUPPLIER	ITAL LTCU	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	rail usage. An observation on 7/2 resident's bed had a of the bed. One in betwee caused a separation ameasured 8 1/2 inchebed was against the bed was against the A staff interview on 7/2 administrative staff C side rail in the resider rail was broken, and the maintenance. The stainclude the side rail. The facility failed to corails and for Black Boresident's medication - Resident #15's qual (MDS) dated 7/17/12 for Mental Status (BIN impaired cognition. The extensive assistance walking, dressing, an independent with eating assistance with personal trails are plan status or weight loss.	25/20/12 did not address side 25/2012 at 6:10 P.M. the quarter rail to the outside of een rail was loose and at the top of the rail that es, and at the bottom es. The other side of the wall. 230/12 at 4:00 P.M. with after he/she observed the at's room and said the side that he/she would report it to aff said the care plan did not eare plan for the use of side of the wall. 250/20/20/20/20/20/20/20/20/20/20/20/20/20	F	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0:	2/2012
	ROVIDER OR SUPPLIER	PITAL LTCU	•	40	EET ADDRESS, CITY, STATE, ZIP CODE 8 DELAWARE STREET INCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	6/3/12 -148 pounds, 6/17/12- 136.5 pounds, 7/12- 134 pounds, 7/12- 134.2 pounds, 146.9. Lab values or and hemoglobin/hem feeding skills, and red. The resident's average percent (%). Staff to maintain oral intake gweight maintenance weight maintenance with the May weight 143.2, which was 60% at the May weight 143.2, which was 60% at month, down 5.3 pour Recommended staff twice a day at medical loss. A nutrition recommer indicated staff notified percent (12.3 pounds days, 6 percent (8.1 pounds	pounds, 6/1/12- 142 pounds, 6/10/12 -139.7 pounds, ls, 6/24/12- 136.4 pounds, 8/12- 131.8 pounds, and ls. ssessment by the registered et indicated a weight of a 4/10/12 albumin 3.3 (low), atocrit 9.3/27 (low), poor quests smaller servings. In the provide well balanced meals, greater than 50 percent and within 5 percent. 8/12 indicated the resident's is time. Interest the pounds in 1	F	279			

PRINTED: 08/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E294	B. WIN	G	08/02/2012			
	ROVIDER OR SUPPLIER ON COUNTY MEM HOSE	PITAL LTCU		40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET /INCHESTER, KS 66097			
(X4) ID PREFIX TAG			I	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY		ILD BE	(X5) COMPLETION DATE	
F 279	Weight down 8 pound 9.5 pounds in 2 mon low sodium diet. Re 6/22/12, 60 ml (up for decrease). Review of the medical (MAR) indicated that ml with medication pay (recommended by die 2012 MAR indicated administer 2 cal 30 m recommended an incommended an incommended an incommended an incommended and incommended incommen	and May 143 pounds. ds in 1 month, weight down ths. The resident was on a commend as stated on om 30 ml due to weight ation administration record staff documented 2 cal 30 ass initiated on 7/5/12 etician on 6/22). The July that staff continued to all after the dietician rease to 60 ml on 7/27. Ininistrative nursing staff B on acated dietary staff recorded cumption and reported values ings. He/she further stated staff to notify the charge nerous refusals of 2 cal. gistered dietician provided of his/her recommendations axed by the charge nurse to ass Identification and and 7/5/12 indicated that each t a minimum monthly and month's weight. The nurse are yould add new nutritional are plan. The nurse and	F	279				

Facility ID: H044101

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '		(X3) DATE SURVEY COMPLETED		
	17E294	B. WING _		08/02/2012		
OVIDER OR SUPPLIER	SPITAL LTCU	ST	TREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE STREET WINCHESTER, KS 66097	00/02/2012		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
served the resident coffee. On 7/30/12 at 11:45 dining area eating, cake and coffee. A observed to eat only an interview with di 9:30 A.M. reported tried to help feed restaff gave 2 cal with resident sometimes. An interview with ac 7/31/12 at 1:45 P.M administrative nursin nursing staff were resident care plans. The facility failed to comprehensive care resident with weight 483.25(h) FREE OF HAZARDS/SUPER. The facility must enenvironment remain as is possible; and adequate supervising prevent accidents.	toast, bacon sausage, and 5 A.M. the resident sat in fried chicken, green beans, to 12:05 P.M. resident y cake. rect care staff G on 7/31/12 at resident became upset if staff sident. He/she further stated in medication pass. The refused. dministrative nursing staff B on the indicated that he/she, ing staff C, and licensed esponsible for updating approvide an individualized, to plan for the dependent those. FACCIDENT VISION/DEVICES sure that the resident is as free of accident hazards each resident receives on and assistance devices to					
	d a census of 25 residents					
	CONTECTION COVIDER OR SUPPLIER DN COUNTY MEM HOS SUMMARY S (EACH DEFICIEN REGULATORY OF The Property of The Property of The Facility failed to comprehensive care resident with weight 483.25(h) FREE OF HAZARDS/SUPER This REQUIREMENT DOVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF The Property of The P	OVIDER OR SUPPLIER DN COUNTY MEM HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 served the resident toast, bacon sausage, and coffee. On 7/30/12 at 11:45 A.M. the resident sat in dining area eating, fried chicken, green beans, cake and coffee. At 12:05 P.M. resident observed to eat only cake. An interview with direct care staff G on 7/31/12 at 9:30 A.M. reported resident became upset if staff tried to help feed resident. He/she further stated staff gave 2 cal with medication pass. The resident sometimes refused. An interview with administrative nursing staff B on 7/31/12 at 1:45 P.M. indicated that he/she, administrative nursing staff C, and licensed nursing staff were responsible for updating resident care plans. The facility failed to provide an individualized, comprehensive care plan for the dependent resident with weight loss. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	OVIDER OR SUPPLIER DN COUNTY MEM HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 served the resident toast, bacon sausage, and coffee. On 7/30/12 at 11:45 A.M. the resident sat in dining area eating, fried chicken, green beans, cake and coffee. At 12:05 P.M. resident observed to eat only cake. An interview with direct care staff G on 7/31/12 at 9:30 A.M. reported resident. He/she further stated staff gave 2 cal with medication pass. The resident sometimes refused. An interview with administrative nursing staff B on 7/31/12 at 1:45 P.M. indicated that he/she, administrative nursing staff C, and licensed nursing staff were responsible for updating resident care plans. The facility failed to provide an individualized, comprehensive care plan for the dependent resident with weight loss. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	OVIDER OR SUPPLIER ON COUNTY MEM HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 served the resident toast, bacon sausage, and coffee. On 7/30/12 at 11:45 A.M. the resident sat in dining area eating, fried chicken, green beans, cake and coffee. At 12:05 P.M. resident observed to eat only cake. An interview with direct care staff G on 7/31/12 at 9:30 A.M. reported resident. He/she further stated staff gave 2 cal with medication pass. The resident sometimes refused. An interview with administrative nursing staff B on 7/31/12 at 1:45 P.M. indicated that he/she, administrative nursing staff C, and licensed nursing staff were responsible for updating resident with weight loss. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILI			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/02	2/2012
	ROVIDER OR SUPPLIER ON COUNTY MEM HOSP	ITAL LTCU		4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	and the sample was a record review, and stafailed to assess for th (#30, and #9) resident ensure the environmental laways remained from the findings included: Resident #30's 7/13 Data Set 3.0 recorded depression, inattention physical behavioral synothers, wandered, and needed extensive assembility/transfer/dressmonths prior to admiss. The fall risk assessmental ascore of 15 which in a high risk for falling. The Evaluation of Sid recorded the resident general, had no falls for adjust position in besafety awareness due problems. The care plan dated for rail usage. An observation on 7/2 resident's bed had a control to the decaused a separation a measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident's had a control to the decaused a separation are measured 8 1/2 inchesident and the decaused a separation are measured 8 1/2 inchesident and the dec	2. Based on observation, aff interview, the facility e safety of side rails for 2 ts of the sample, failed to ent for 3 of 3 resident se of accident hazards. 6/12 admission Minimum of the resident had mild in, disorganized thinking, reptoms directed toward of intruded on others, sistance with bed sing/toileting, had a fall 2-6 sion, and had no restraints. ent dated 6/21/12 recorded idicated the resident was at the Rail Usage dated 6/21/12 had a history of falls in from the bed, used side rails ed, and had decreased to confusion or judgement in a confusion or judgement in the side of the confusion of the confu	F	323			

PRINTED: 08/03/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE STREET WINCHESTER, KS 66097	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
JEFFERSON COUNTY MEM HOSPITAL LTCU 408 DELAWARE STREET			17E294	B. WIN	G	 	08/0	2/2012
· · · · · · · · · · · · · · · · · · ·			ITAL LTCU		4	08 DELAWARE STREET		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE	
F 323 Continued From page 10 bed was against the wall. A staff interview on 7/30/12 at 4:00 P.M. with administrative staff C after he/she observed the side rail in the resident's room, said the side rail was broken, and that he/she would report it to maintenance. The staff said the care plan did not include the side rail. According to the Federal Drug Administration (FDA) Hospital Bed Safety Workgroup as of June 2001 revised the dimension within a side rail opening to less than 120 millimeters or 4 3/4 inch to prevent entrapment of body parts. The facility failed to care plan for the use of side rails and failed to assess the safety of the side rail. - Resident #9's 7/10/12 quarterly Minimum Data Set 3.0 recorded the resident was severely cognitively impaired, had no behaviors, needed extensive assistance with bed mobility, and transfer, and had no restraints. The side rail assessment dated 7/9/12 recorded the resident had a history of falls including from the bed, did not attempts to climb over or around the rails, had decreased safety awareness, made attempts to get out of bed, could not get infout of bed safely without any human assistance or assistive device and used the rail to aid position in bed. Had both quarter rails up. The care plan dated 10/3/1/10 recorded the resident liked the top quarter rails up to grab a hold of and help him/herself turn in bed.	F 323	bed was against the A staff interview on 7/ administrative staff C side rail in the resider was broken, and that maintenance. The sta include the side rail. According to the Fede (FDA) Hospital Bed S 2001 revised the dime opening to less than to prevent entrapmen The facility failed to carails and failed to assirail. - Resident #9's 7/10/ Set 3.0 recorded the incognitively impaired, if extensive assistance transfer, and had no r The side rail assessmenthe resident had a his the bed, did not attem the rails, had decreas attempts to get out of bed safely without any assistive device and it in bed. Had both quar The care plan dated if resident liked the top	wall. 30/12 at 4:00 P.M. with after he/she observed the nt's room, said the side rail he/she would report it to off said the care plan did not eral Drug Administration afety Workgroup as of June ension within a side rail 120 millimeters or 4 3/4 inch to foody parts. are plan for the use of side ess the safety of the side 12 quarterly Minimum Data resident was severely had no behaviors, needed with bed mobility, and restraints. Inent dated 7/9/12 recorded tory of falls including from apts to climb over or around led safety awareness, made bed, could not get in/out of y human assistance or used the rail to aid position ter rails up.	F	323			

Facility ID: H044101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE .DING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER	PITAL LTCU		408	T ADDRESS, CITY, STATE, ZIP CODE DELAWARE STREET ICHESTER, KS 66097	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	resident's bed had a the bed. One in-betwo caused a separation measured 8 1/2 inches measured 4 1/2 inches and a staff interview 7/30 care staff I who said rails to help with transplant A staff interview on administrative staff 0 side rail in the residerail was broken, and maintenance. At 4:1 resident's bed and education was broken, and maintenance and education to the Feo (FDA) Hospital Bed 2001 revised the dimopening to less than to prevent entrapmed. The facility failed to rail. - Observations during one on 7/25/12 from 7:00 A environmental tour of 2:00 P.M. to 2:35 P. Hall B:	/25/2012 at 3:13 P.M. the quarter rail to the outside of ween rail was loose and at the top of the rail that les, and at the bottom nes. 0/12 at 3:55 P.M. with direct the resident used the side asfer/repositioning. 7/30/12 at 4:00 P.M. with C., after he/she observed the ent's room and said the side that he/she would report it to 0 P.M. the staff removed the exchanged it with a new one. deral Drug Administration Safety Workgroup as of June mension within a side rail 120 millimeters or 4 3/4 inch and of body parts. assess the safety of the side ing the initial tour and stage 9:00 to 5:00 P.M. and on M. to 10;30 A.M. and during on 7/26/12 from approximately M., revealed the following: jagged and splintered wood	F	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER ON COUNTY MEM HOSP	ITAL LTCU		40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	to the bathing/toileting * lack of a non-skid so the bathing room Hall C: * a buckled area in the (where the a wing add a rubbery substance of side of the hallway in about 2 feet in length side of the hallway wharea Hall D: * lack of a non-skid so the bathing room An interview on 7/26/ P.M. with maintenance present material to co floors where it settled loosen up and buckle He/she noted there we any the bathing areas rooms, and he/she was	ed wood on the outside door groom urface in the bathing area of e middle of the hallway dition started), covered with was buckled on the right several areas covered and loose areas to the left nich covered about 1 feet of urface in the bathing area of 12 at approximately 2:30 the staff H said they used the over the uneven level of the the/she said it started to after only a few months, as not a non-skid surface to as in 2 of 3 bathing/shower as not aware of the started to	F	323			
	preventive routine ma specific areas for rou policy note for mainte orders submitted by s environmental rounds	dure dated 11/8/11 for sintenance failed to note tine maintenance. The nance staff to check work staff members daily and do a monthly.					
	staff H at 3:30 p.m. sa	aid members of the safety					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
	17E294	B. WIN	G		08/0	2/2012
	PITAL LTCU		40	8 DELAWARE STREET		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	1		(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
committee made more He/she said they identified areas, jagged a chipped and loose flo staff fixed the areas to He/she said he/she w missed the areas of maintenance staff H The facility failed to e	nthly environmental rounds. Intified such things as uneven and splintered wood and spl	F	323			
residents. 483.25(i) MAINTAIN	NUTRITION STATUS	F	325			
assessment, the faci resident - (1) Maintains accepta status, such as body unless the resident's demonstrates that th	lity must ensure that a able parameters of nutritional weight and protein levels, clinical condition is is not possible; and					
by: The facility census v sample included 12 r reviewed for weight l record review, and st	vas 25 residents. The esidents with 3 residents oss. Based on observation, aff interview, the facility					
	SUMMARY ST (EACH DEFICIENCY REGULATORY OR Continued From page committee made mon He/she said they iden floor areas, jagged an chipped and loose floor staff fixed the areas of the/she said he/she with missed the areas of maintenance staff Hour The facility failed to e safe and free of accid residents. 483.25(i) MAINTAIN UNLESS UNAVOIDA Based on a resident's assessment, the facil resident - (1) Maintains accept status, such as body unless the resident's demonstrates that thi (2) Receives a theray nutritional problem. This REQUIREMENT by: The facility census we sample included 12 r reviewed for weight lor record review, and st failed to prevent weig (#15 and #28).	CONTINUED FOR SUPPLIER ON COUNTY MEM HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 committee made monthly environmental rounds. He/she said they identified such things as uneven floor areas, jagged and splintered wood and chipped and loose floor tiles, then maintenance staff fixed the areas they identified as they could. He/she said he/she was not sure how they missed the areas of concern revealed to maintenance staff H on the environmental tour. The facility failed to ensure the environment was safe and free of accident hazards for the residents. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility census was 25 residents. The sample included 12 residents with 3 residents reviewed for weight loss. Based on observation, record review, and staff interview, the facility failed to prevent weight loss for 2 of 3 residents (#15 and #28).	Continued From page 13 committee made monthly environmental rounds. He/she said they identified as they could. He/she said he/she was not sure how they missed the areas of concern revealed to maintenance staff fixed to ensure the environmental tour. The facility failed to ensure the environment was safe and free of accident hazards for the residents. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the residents clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility census was 25 residents. The sample included 12 residents with 3 residents reviewed for weight loss. Based on observation, record review, and staff interview, the facility failed to prevent weight loss for 2 of 3 residents (#15 and #28).	A BUILDING 17E294 A BUILDING B. WING ROYIDER OR SUPPLIER ON COUNTY MEM HOSPITAL LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 Committee made monthly environmental rounds. He/she said they identified such things as uneven floor areas, jagged and splintered wood and chipped and loose floor tiles, then maintenance staff fixed the areas they identified as they could. He/she said he/she was not sure how they missed the areas of concern revealed to maintenance staff flor the environmental tour. The facility failed to ensure the environment was safe and free of accident hazards for the residents. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility census was 25 residents. The sample included 12 residents with 3 residents reviewed for weight loss. Based on observation, record review, and staff interview, the facility failed to prevent weight loss for 2 of 3 residents (#15 and #28).	This REQUIREMENT is not met as evidenced by: This REQUIREMENT IDENTIFICATION NUMBER: 17E294 A BUILDING	This REQUIREMENT is not met as evidenced by: 17E294 This REQUIREMENT is not met as evidenced by: 17E294 This REQUIREMENT is not met as evidenced by: 17E294 This REQUIREMENT is not met as evidenced by: 17E294 This REQUIREMENT is not met as evidenced by: 17E294 This REQUIREMENT is not met as evidents review, and \$25 or \$25 of 3 residents reviewed for weight loss. For 20 of 3 residents reviewed for weight loss for 2 of 3 residents reviewed for weight loss for 2 of 3 residents reviewed for weight loss for 2 of 3 residents (#15 and #28).

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E294	B. WIN	G		08/02/2012		
	OVIDER OR SUPPLIER	PITAL LTCU	'	408	ET ADDRESS, CITY, STATE, ZIP CODE B DELAWARE STREET NCHESTER, KS 66097	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 325	Continued From page	e 14	F	325				
		9/11 admission Minimum d the resident weighed 127						
	6/22/12 recorded the cognitively impaired, mood disorder, had nindependent with beceating, walked in root pain, received a diure	had no signs/symptoms of a						
	cognitive impairment resident had progress difficulty dealing with dementia created, was educated and widely hospitalized with an ableed which caused hweak/unstable, had medications for hypehypokalemia, anemia	o falls, took various rtension, constipation, and recent GI bleed, took tap water at bedside, as well						
	The CAA for nutrition	did not trigger.						
	pounds on 7/01/2012 118 pounds on 3/06/2 1/01/2012. The reside weight to the third we	the resident weighed 110 ,109 pounds on 6/01/2012 , 2012, and 132 pounds on ent lost 6.78% from the first light (4 months), and the from the first weight to the hs)						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER	SPITAL LTCU		408	T ADDRESS, CITY, STATE, ZIP CODE DELAWARE STREET ICHESTER, KS 66097	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	his/her daily afternormonday-pink grape Wednesday-green wednesday-fresh fruit, Sunday-banana. Bed time snacks: Twednesday-fresh from Saturday-cucumber Also listed was low in carton. The care plan listed 1/3/12 Zoloft (an arron daily, and compromprehensive merappointment with the for 7 days, 2/8/12 Lofor 7 days for pneur with the physician from the problem and supplement, and 7/stimulant) 80 mg two The care plan did no The admission nutries.	d 2/10/12 recorded a list of on snack schedule: fruit, Tuesday-cucumber, grapes, Thursday-yogurt, aturday-fresh orange, and uesday-yogurt, ruit, Thursday-pink grapefruit, r., and Sunday-fresh orange. salt soup, and chicken broth the following approaches: ti-depressant) 25 milligram acrease Lasix (a diuretic) to 40 alete blood count, abolic panel, 1/9/12 appointment or severe headache, 2/15/12 omg for depression, 2/20/12 alar with super cereal daily at a 2 cal supplement at a 3 ce times daily, 3/19/12 ar esident refused the 11/12 Megace (an appetite rice daily. ot address weight loss as a at state any goals.	F	325			
	resident's height wa	ered dietician, recorded the as 67 inches, weight 127.3 Instant Breakfast discontinued					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0:	2/2012
NAME OF PROVIDER OR S JEFFERSON COUNTY		PITAL LTCU	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097		
PREFIX (EAC	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
as the res watch wei meals. The reside recorded to loved bake toast, oatrentrees sucasserole, preferred tomatoes. Nutrition mesident's food intake received 7. Nutrition mesorded in 1/12, 131. down 4.2 months, redifficulty we exacerbate slightly un regular die weight back. Nutrition mesorded in 1/17.6 pour 132.6 pour month, we regular die had maste of the skulptions.	ght, and make the resident food preche resident ged potatoes meal, sausauch as chick, liked fruit, fruit over swart over saus 53% of meal to the dated 2 resident we 5 pounds in 1 received a low of lung der weight, get with headack ion of lung der weight, get with super ck near normal to the sident mas, 2/12 with the resident mas, 2/12 with the resident mas, 2/12 with super ck with super ck with super chiditis (an in lil. The mass	red fruit as snacks, will aintain intake over 50-75% at eferences dated 9/10/11 received a regular diet, iliked scrambled eggs, iliked eggs,	F	325			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		17E294	B. WIN	G		08/0:	2/2012	
	ROVIDER OR SUPPLIER	ITAL LTCU	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 325	recommend to start 3 times daily to slow we Nutrition note dated 7 on 7/12 was 110 pour food intake was 61 % 0.9 pounds in 30 days food and drink choice continue to monitor. The list of residents wand super cereal provide resident did not redid not receive super. An observation on 7/3 resident sat in his/her table eating a bowl of resident ate approxim. An interview on 7/31/administrative nursing had a lot of edema, a the Lasix dose on 1/4 to 40 mg, and it rema said the resident was facility notified the phloss. The staff said the weighed. The staff snacks in the middle asked for it. The staff weight loss, the care but that there were no goals listed. An interview on 7/31/	increased weight loss, 0 milliliter (ml) 2 cal three eight loss. 2/26/12, the resident's weight hds, on 6/12, 109 pounds, in 30 days, weight increase is, resident requested his/her is for most meals, will 2/ho received supplements wided by the kitchen revealed eceive any supplements and cereal at breakfast. 30/12 at 8:15 A.M. the is wheel chair at the breakfast is oatmeal independently. The eately 50-60%. 12 at 7:30 A.M. with it is staff B stated the resident and the physician increased independently. The staff on weekly weights, and the existing after each weight in the properties of the night as he/she often in the staff of the night as he/she of	F	325				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		RUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING			08/0	2/2012
	OVIDER OR SUPPLIER	PITAL LTCU		408 DELAW	ESS, CITY, STATE, ZIP CODE ARE STREET TER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	resident's name was be, and wrote the resinformed the cook. An interview 7/31/12 staff F said the regist recommended super changed the diet to rewas not on our list. To dietician came in onceded him/her more communicated with his staff said he/she gave his/her weight concercompiled meal percesaid the dietician on a supplement, 2 cal. An interview with the A.M. the resident was he/she lost weight, die he/she was probably height. An interview 8/1/12 with said he/she came to basis and he/she sat and talked over all the brought to his/her attroncern. He/she ther Changes form with all and left that with admitted with the charge nurse for the physician's signercommendation need when he/she returned.	I at breakfast, revealed the not on the list, but should ident's name on the list and at 9:00 A.M. with dietary ered dietician on 2/18/12 cereal for breakfast, egular, but super cereal just he staff said the registered e a month, but if he/she frequently, he/she im/her via phone or fax. The ethe registered dietician all ms weekly and monthly, and htages monthly. The staff 3/13/12 recommended the resident on 7/31/12 at 11:20 s alert and oriented said d not know why, and said a bit underweight for his/her with consultant K at 1:25 P.M. the facility on a monthly down with dietary staff Feresidents who the facility ention with a nutrition of filled out a Request for Diet I his/her recommendations sinistrative nursing staff B or e, and wrote a separate form	F3	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0)2/2012	
	OVIDER OR SUPPLIER	SPITAL LTCU		408	T ADDRESS, CITY, STATE, ZIP CODE DELAWARE STREET ICHESTER, KS 66097	3073		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 325	the facility brought tagain because of a said they did not go staff followed his/he discontinued a recoresident refusal. The discussions with the were doing. When a could be more effect consultant, the consultant, the consultant, the consultant, the consultant, the consultant of the columns on it titled to completed was under the facility failed to nutritional intervention reassess after the resupplement for this weight loss. The admission Minital Alama of the completed was under the complete was a supplement for this weight loss. The admission Minital Alama of the completed was under the complete weight of 134, and a status (BIMS) of 3 is cognition. The residual status (BIMS) of 3 is cognition. The residual status (BIMS) of 3 is cognition. The residual status of the weight loss. Review of the weight loss.	he recommendation unless he resident to his/her attention nutrition concern. The staff back to each chart to check if r recommendation, or if staff mmendation because of e staff said he/she had verbal e facility staff on how residents asked how communication tive between facility staff and sultant said they felt the ange form that he/she utilized dations had 2 additional Comments and Date lerutilized. provide recommended ons as planned, and failed to esident refused a nutritional resident with significant mum Data Set (MDS) dated #15 indicated a weight of MDS dated 7/17/12 reported a Brief Interview for Mental indicating severely impaired dent required extensive mobility, transfer, walking, ng. The resident was ating.	F	325				

PRINTED: 08/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	ROVIDER OR SUPPLIER	PITAL LTCU	,	40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 325	6/17/12 -136.5 poun 7/1/12-134 pounds, 128.8 pounds, 7/22/7/29/12- 134.2 poun weight loss of 8%. A 4/6/12 (admission by the registered die 146.9 pounds. Lab albumin level at 3.3 hemoglobin/hemator poor feeding skills, a servings. The resid 60 percent. The facil balanced meals and oral intake greater the weight within 5 percent A nutrition progress dietician on 4/8/12 ir intake was 60 percent would continue to m A nutrition progress on 6/22/12 indicated pounds, May weight resident's weight was month, down 5.3 por resident received a 1 62-86 percent intake 6/19/12 revealed the was 3.5-5.2. Anemia mental status, demedecreased. Weight Recommend the face	6/10/12 -139.7 pounds, ds, 6/24/12 -136.4 pounds, 7/8/12- 131.8 pounds, 7/15-12 134.8 pounds, and ds indicating an overall date) nutrition assessment tician indicated a weight of values on 4/10/12 listed (low), and crit 9.3/27 (low). He/she had and requested smaller ent's average oral intake was ity was to provide well the resident to maintain an item. Inote by the registered didicated the resident's food int at this time and he/she onitor. Inote by registered dietician the June weight was 141.8 was 143.2 pounds. The is down 1.4 pounds in 1 unds in 2 months. The low sodium (diet) and had at Laboratory results dated a albumin level was 3, normal and interest and the second interest and the s	F	325			

Facility ID: H044101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER DN COUNTY MEM HOSF	PITAL LTCU		40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET /INCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	indicated staff notified percent (12.3 pounds days, 6 percent (8.1 pmonth, and physician milliliters three times A nutrition progress ron 7/27 indicated the June 141.8 pounds, pounds in 1 month, a in 2 months. The residiet. Albumin 3 (norrequested diet consurecommend a supple Blood Urea Nitrogen but did recommend a mI twice a day). Recimed pass 60 mI (up fidecrease). Review of meal the cindicated an average the dietician progress in April, and 62-86 % Review of the medication pass (recommended by digreview of the July 20 resident refused 2 caresident refused 2 caresi	dation sheet dated 7/3/12 d the physician of an 8.5) weight loss in the past 90 bounds) weight loss in past order on 7/5/12 of 2-cal 30 d day with medication pass. Note by registered dietician July weight 133.7 pounds, May 143 pounds, down 8 and weight down 9.5 pounds ident received a low sodium hal 3.5-5.2). The physician lt. The dietician did not ment due to increased level (BUN) and creatinine, s stated on 6/22/12 (2 cal 30 bommend facility staff to start from 30 ml due to weight consumption records intake in July of 49% and intake in May/June. Aution administration record documented 2 cal 30 ml initiated on 7/5/12 etician on 6/22/12). Further 12 MAR indicated the	F	325			
	from 30 ml to 60 ml o	recommended an increase n 7/27/12. evels (a measure of the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER	PITAL LTCU	·	40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET /INCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	4/10/12 3.3 (normal r. (normal range), 5/2/1 6/12/12 3.2 (low), and Observation on 7/30/fed him/herself in the sausage, and coffee. On 7/30/12 at 11:45 / dining area, staff serv green beans, cake ar resident ate only cake An interview with dire 9:30 A.M. reported the the staff tried to help further stated staff at medication pass, but refused. An interview with adm 7/31/12 at 1:45 P.M. recorded the resident reported values at ca further stated that he/the charge nurse if a refusals of 2 cal. He/dietician provided him recommendations an the charge nurse to the acknowledged that in on 6/22/12 were not in An interview on 8/1/1	ange of 3.5-5.2), 4/25/12 3.5 2, 3.4 (low), 5/9/12 3.3 (low), 6/19/12 3.1(low). 12 at 7:40 A.M. the resident dining room, toast, bacon A.M. the resident sat in the red him/her fried chicken, and coffee. At 12:05 P.M. the resident became upset if feed resident. He/she tempted to give 2 cal with that sometimes the resident ministrative nursing staff B on indicated dietary staff 's meal consumption and re plan meetings. He/she resident had numerous she stated the registered h/her with a copy of his/her d they were then faxed by the physician. He/she terventions recommended initiated until 7/5/12.	F	325			
	monthly visit the facili	ty provided him/her with a ling weight loss, which					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WINC			08/0:	2/2012
	ROVIDER OR SUPPLIER	PITAL LTCU		408	ET ADDRESS, CITY, STATE, ZIP CODE DELAWARE STREET NCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	F completed. He/she completed a Request he/she had recomme facility staff and the phe/she gave the commurse staff B or the completed a physician's order. Corequired a physician's returned the following check to see if the far recommendation unlearesident to his/her att nutrition concern. The facility Weight Low Monitoring policy data weighed each resider and compared with the dietary manager control dietician for a full revision recommendations. The nurse notified the recommendations the required a physician of dietary interventions physician's order will monitored by the nurse physician's order will monitored by the nurse and dietary maintervention occurred. The clinical record lack was unavoidable. The and implement interventions.	g staff B and/or dietary staff e stated that he/she for Diet Changes when indations to communicate to hysician. He/she stated that pleted form to administrative harge nurse, for a consultant J stated that 2 cal is order. When he/she is month, he/she would not collity followed up on his/her ess the facility brought the ention again because of a consultant J stated that 2 cal is order. When he/she is month, he/she would not collity followed up on his/her ess the facility brought the ention again because of a consultant J stated that 2 cal is order. When he/she is month, he/she would not consulting again because of a consultant J stated that 2 cal is order. When he/she is dentification and is prior month's weight. The macted the consulting ew of resident's needs, and for nutritional interventions. It is provider of any is dietician wrote which corder. Recommended which did not require a be implemented and is and the dietary manager. It is a care plan. The mager monitor that d as care planned. consultant J stated that consultant consultant J stated that consultant J stated that consultant consul	F3	325			

PRINTED: 08/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E294	B. WING	i		08/0	2/2012	
	OVIDER OR SUPPLIER	ITAL LTCU		408 D	ADDRESS, CITY, STATE, ZIP CODE ELAWARE STREET CHESTER, KS 66097	, 00/0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 329 SS=E	UNNECESSARY DR Each resident's drug unnecessary drugs. A drug when used in ex duplicate therapy); or without adequate moi indications for its use adverse consequence should be reduced or combinations of the re Based on a comprehe resident, the facility m who have not used at given these drugs und therapy is necessary as diagnosed and dor record; and residents drugs receive gradua behavioral intervention	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate g or in the presence of es which indicate the dose discontinued; or any easons above. The ensure that residents ntipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and	F3	29				
	by: The facility reported and the sample was record review, and stated to identify and record record review.	is not met as evidenced a census of 25 residents 12. Based on observation, aff interview, the facility monitor side effects for 4 idents out of 10 residents ew.						

Facility ID: H044101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING			08/0	2/2012
	OVIDER OR SUPPLIER	PITAL LTCU		408 DEL	DRESS, CITY, STATE, ZIP CODE AWARE STREET ESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Continued From page Resident #3 Physici July 2012 recorded the included Buspar, and anxiety, and Seroque medication for demer The quarterly Minimu 5/1/12 recorded a socon the Brief Interview independent without stransfers, walking in runit, eating, toilet use required limited assist and bathing; balance to stabilize without stabowel and bladder are and anti-anxiety med. The Care Area Assess documented the psycon a quarterly and as benefit statements and dictated notes. Medicattempted and the resistency seroquel and Buspar psychiatric issues and medication for the particular to the page of the Lexi-Comp Drug	an Order Sheet (POS) for the resident's medication anti-anxiety medication for II, an anti-psychotic attia with behaviors. In Data Set (MDS) 3.0 dated for of 1 (severely impaired) for Mental Status (BIMS), set up with bed mobility, coom/corridor, locomotion on and personal hygiene; to of one staff with dressing not steady but resident able aff assistance; continent of the dreceived anti-psychotic dication. Issment (CAA) dated 8/9/11 chiatrist followed the resident needed basis. The risk opear in the psychiatrist's ation reduction trials were sident currently received. The resident had direquired psychotropic at several years. Reference Handbook of	F 3	29		IF RIATE	
	Seroquel: "Elderly pa psychosis treated wit increased risk of deat Most deaths appeare or infectious in nature	ndbook, 16 th edition, g U.S. Boxed Warning for tients with dementia-related h anti-psychotics are at an th compared to placebo. d to be either cardiovascular e. Seroquel is not approved ementia-related psychosis."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E294	B. WIN	G		08/0:	2/2012	
	OVIDER OR SUPPLIER	ITAL LTCU	·	40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET /INCHESTER, KS 66097			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 329	Tramadol, Tylenol, ar the medication Seroque Review of the facility Maintaining Black Bo 11/2011 recorded a maying a Black Box Vilisted the specific methe care plan and plastaff kept on the side review as needed. Review of the facility Behavior Monitoring Serocorded for staff to record of targeted be receiving anti-psychosedative/hypnotic druthe need to decrease based on occurrence Review of Behavior May 2012, 5/2012, and 6 behaviors of hitting, a wandering in and out	ne U.S. Boxed Warnings for and Lasix but did not include uel. policy/procedure of x Warning Alerts dated nedication identified as /arning (BBW). The facility dication warning attached to ced in the BBW book, which of the medication cart for policy/procedure of Use of Sheets dated 8/2011 maintain a quantitative naviors for residents tic, anti-anxiety, and gs, to assist in evaluation of or increase medication of behaviors. Monitoring Flow Sheets dated 6/2012 identified the target nnoying peers, anxiety, of peers rooms, throwing ropriate contact with male ut did not indicate the ation as Buspar, an	F	329	DEFICIENCY)			
	anti-psychotic medica An observation on 7/3 resident ambulated th he/she carried a mag	ation. 31/12 at 12:33 P.M. the proughout the facility while						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0:	2/2012
	OVIDER OR SUPPLIER	ITAL LTCU	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	licensed nursing staff on the behavior monitor on the behavior monitor of licensed nursing staff behavior monitoring monitoring notebook exhibited a specific bestaff documented the A staff interview on 7 administrative nursing was unaware that Se Warning and the phanhim/her if Seroquel had unaware of need to it different drug classific immediately. The facility failed to it side effects of a medit warning and failed to effectiveness of anti-a	ted medication aides at's behaviors, but the documented the behaviors toring flow sheets. 231/12 at 2:00 P.M. with D reported staff kept flow sheets in the behavior and when a resident ehavior the licensed nursing behavior. 231/12 at 7:30 A.M. with g staff B reported he/she roquel had a Black Box macist did not notify ad a BBW. He/she was lentify target behaviors for cations but would rectify this	F	329			
	Data Set 3.0 recorded depression, inattention physical behavioral subters, wandered, and needed extensive ass	sistance with bed sing/toileting, and had a fall					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		17E294	B. WING			02/2012	
	ROVIDER OR SUPPLIER ON COUNTY MEM HOSP	ITAL LTCU		STREET ADDRESS, CITY, STA 408 DELAWARE STREET WINCHESTER, KS 660			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page The record lacked an Movement Scale (AIM) The care plan dated of resident had combative resident used both artried to help him/her resident with depression anti-depressant) 20 m care plan recorded the of psychosis and receanti-psychotic) 12.5 m staff to monitor for addresident received Ola 5 mg as needed ever behaviors and listed to The care plan recorded become quite agitated resident became angulate resident took Metion The care plan did not Warnings for Seroque Metformin. The behavior monitor 7/12 recorded the following medical services and listed the following medical services and liste	y Abnormal Involuntary (IS) assessment. (S/20/12 recorded the (Ye behaviors, and that the ms to strike out at staff who emain safely inside the in recorded the resident and received Celexa (an illiligrams (mg) daily. The e resident had a diagnosis sived Seroquel (an ing at 3:00 P.M., and for the everse side effects. The inzapine (an anti-psychotic) y 4 hours for dementia with he potential side effects. ed that the resident could id, especially when the ery. The care plan recorded formin 500 mg for diabetes. identify the U.S. Black Box el, Olanzapine, and	F 3				
	as needed. The Geriatric Dosage page 1509 recorded f Warning/Precautions	Handbook, 16 th Edition, or Quetiapine (Seroquel): (U.S. Boxed Warning): a-related					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E294	B. WING		08	/02/2012	
	OVIDER OR SUPPLIER	PITAL LTCU	40	EET ADDRESS, CITY, STATE, ZIP CODE 8 DELAWARE STREET INCHESTER, KS 66097		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 329	death compared to p approved for treatment psychosis. The Geriatric Dosage page 1276 recorded Warning/Precautions patients with dement with antipsychotics a death compared to p to be either cardiovas In addition, an incread cerebrovascular effect. The Geriatric Dosage page 1101 recorded Warning/Precautions Lactic acidosis as a reconsequence of them. An observation on 7/ resident sat in the whappeared to nap. An interview 7/3/12 administrative staff B resident's behavior milisted the specific bellisted 2 different drug and Seroquel (an antispecify which behavid drugs, which made it monitor the medication. An interview 7/31/12 administrative nursin	rere at an increased risk of lacebo. Quetiapine was not ant of dementia related Handbook, 16 th Edition, for Olanzapine: (U.S. Boxed Warning): ia-related psychosis treated re at an increased risk of lacebo. Most deaths appear scular or infectious in nature. sed incidence of cts has been reported. Handbook, 16 th Edition, for Metformin: (U.S. Boxed Warning): are, but potentially severe apy with Metformin. 30/12 at 7:30 A.M. the neel chair by the aviary and tt 7:15 A.M. with said regarding the nonitoring sheets the facility naviors the staff monitored, is, Ativan (an anti-anxiety) in-psychotic) but did not ors related to which of the difficult for the staff to ons for efficacy.	F 329				

PRINTED: 08/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		17E294	B. WIN	G		08/0	2/2012	
	ROVIDER OR SUPPLIER	ITAL LTCU	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 329	resident's Black Box or The facility failed to in related to which psychological behavior monitoring from the ficacy, failed to care warning medication, anti-psychotic medicateffects. - Resident #9's 7/10/Set 3.0 recorded the cognitively impaired, extensive assistance transfer, and received medication. The Care Area Assess 10/11/11 for mood standard a diagnosis of demilligrams (mg) daily. Parkinson's disease we resident appeared mooften actually was. That times, but appeared time. The care plan dated resident had social is disease related demeloss, and had a histor depression/hallucinat staff for most activitie	e plan did not include this Warning medication. Identify which behaviors hotropic medication on the form for the monitoring of e plan for the Black Box and failed to monitor the ation for potential adverse 12 quarterly Minimum Data resident was severely had no behaviors, needed with bed mobility, and did an anti-depressant Issment worksheet dated atterecorded the resident pression and took Paxil 20 Because of the resident pression and took Paxil 20 Because of the resident's with it's mask like faces the pre depressed than he/she he resident became moody did stable on Paxil at this 10/31/10 indicated the colation due to Parkinson's ential and severe hearing by of ions/delusions, needed one is of daily living cares, pression, and for the staff to in mental status and	F	329				

Facility ID: H044101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G_		08/02	2/2012
	OVIDER OR SUPPLIER ON COUNTY MEM HOSP	ITAL LTCU		4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	resident slept well, had dreams, in no appare resting tremor. An observation on 7/2 resident sat in his/her napping. An interview 7/31/12 a	ess note 7/11/12 recorded the and previously reported vivid and distress and with no 26/2012 at 2:30 P.M. the easy chair in their room at 7:15 A.M. with said the facility had not uction for Paxil. The	F	329			
	dated 6/5/12 recorded cognitively intact, had independent with all a received anti-psychot medications. The Care Area Asses 6/5/12 for psychotropi psychiatrist followed to problems & medication Zyprexa (anti-psychotrelated behaviors, and The care plan dated & socially inappropriate resident sometimes for accusatory behaviors	ual Minimum Data Set 3.0 d the resident was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WING		08/0	2/2012
	OVIDER OR SUPPLIER DN COUNTY MEM HOSP	ITAL LTCU	S	STREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	angry, or touched fem staff to help keep my psychiatrist, and "if I a someone took someth supportively and help concerns, remind me female residents" The behavior sheet d the following behavior delusions/paranoia/re following medications and Remeron 30 mg. An observation on 7/3 resident sat in his/her room, waiting to go of An interview 7/31 at 7 staff B said regarding monitoring sheets the behaviors the staff medifferent drugs, Zypre Remeron (an anti-dep which behaviors for effical medications for effical	times I threaten others when hale residents" and for the appointments with the am upset because I think hing from me, listen to me me with legitimate as needed not to touch ated 6/12 and 7/12 recorded rs: If usal of cares, and the resident in the living ut on an outing. If A.M. with administrative the resident's behavior a facility listed the specific ponitored, and listed 2 exa (an anti-anxiety) and pressant) but did not specify ed to which of the drugs, it for the staff to monitor the	F 32	29		
F 428 SS=E	related to which psychehavior monitoring for efficacy. 483.60(c) DRUG RECURREGULAR, ACT O	hotropic medication on the orm for the monitoring of GIMEN REVIEW, REPORT	F 42	28		
		e a month by a licensed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	OVIDER OR SUPPLIER	SPITAL LTCU	'	4	REET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 428	the attending physic	ge 33 st report any irregularities to sian, and the director of reports must be acted upon.	F	428			
	This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents and the sample was 12. Based on observation, record review, and staff interview, the facility drug regimen review failed to identify and report drug irregularities for 4 (#3, #9, #30, #10) residents out of 10 residents sampled for drug review.						
	July 2012 recorded included Buspar, ar	cian Order Sheet (POS) for the resident's medication anti-anxiety medication for uel, an anti-psychotic entia with behaviors.					
	The quarterly Minim 5/1/12 recorded a s on the Brief Intervie independent withou transfers, walking ir unit, eating, toilet us required limited ass and bathing; balance to stabilize without st	num Data Set (MDS) 3.0 dated core of 1 (severely impaired) w for Mental Status (BIMS), at set up with bed mobility, a room/corridor, locomotion on se, and personal hygiene; ist of one staff with dressing e not steady but resident able staff assistance; continent of and received anti-psychotic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUIL			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/02	2/2012
	OVIDER OR SUPPLIER	PITAL LTCU	•	40	EET ADDRESS, CITY, STATE, ZIP CODE 08 DELAWARE STREET VINCHESTER, KS 66097		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Continued From page		F	428			
	documented the psycon a quarterly and as benefit statements and dictated notes. The fareduction and the res Seroquel and Buspar psychiatric issues and medication for the paredication for the following Seroquel: "Elderly paredicated with increased risk of death Most deaths appeared or infectious in nature for the treatment of different forms of the facility Maintaining Black Boom 11/2011 recorded and having a Black Box Whisted the specific methe care plan and plast staff kept on the side review as needed. Review of the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring States and staff kept on the facility Behavior Monitoring Staff kept on the facilit	d required psychotropic st several years. Reference Handbook of adbook, 16 th edition, g U.S. Boxed Warning for tients with dementia-related th anti-psychotics are at an th compared to placebo. d to be either cardiovascular e. Seroquel is not approved ementia-related psychosis." The U.S. Boxed Warnings for and Lasix but did not include quel. policy/procedure of x Warning Alerts dated anedication identified as Varning (BBW). The facility dication warning attached to ced in the BBW book, which of the medication cart for policy/procedure of Use of Sheets dated 8/2011 maintain a quantitative					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
	ROVIDER OR SUPPLIER ON COUNTY MEM HOSP	ITAL LTCU		4	REET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF	JLD BE	(X5) COMPLETION DATE
F 428	the need to decrease based on occurrence Review of Behavior M 4/2012, 5/2012, and 6 behaviors of hitting, a wandering in and out things, cursing, inapp peers and pouting, bu corresponding medica anti-anxiety medicatic anti-psychotic medica Review of the Pharma dated 7/20/12, 6/18/1 2/15/12, 1/18/12, 12/2 identify the medication An observation on 7/3 resident ambulated the/she carried a mag A staff interview on 7/4 direct care staff G star monitored the resider licensed nursing staff on the behavior monitoring staff behavior monitoring monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring notebook in the staff interview on 7/1 intersed nursing staff behavior monitoring notebook in the staff interview on 7/1 interview on 7/	tic, anti-anxiety, and gs, to assist in evaluation of or increase medication of behaviors. Monitoring Flow Sheets dated 6/2012 identified the target innoying peers, anxiety, of peers rooms, throwing ropriate contact with male at did not indicate the ation as Buspar, an on, or Seroquel, an ation. Cacist Communication Sheet 2, 5/15/12, 4/16/12, 3/7/12, 15/11, and 11/16/11 failed to in irregularities. Call 12 at 12:33 P.M. the aroughout the facility while azine and purse. Call 12 at 9:43 A.M. with ted medication aides at's behaviors, but the documented the behaviors toring flow sheets. Call 12 at 2:00 P.M. with D reported staff kept flow sheets in the behavior and when a resident ehavior the licensed nursing	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
17E294		B. WING			08/02/2012		
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU				408 [T ADDRESS, CITY, STATE, ZIP CODE DELAWARE STREET ICHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	administrative nursing was unaware that Se Warning and the phan him/her if Seroquel had unaware of need to it different drug classific immediately. An interview on 8/1/1 consultant pharmacis monitored the medical basis. He/she monito supporting diagnosis, related to prescribed medications for poter He/she alerted staff of Box Warnings (BBW) presence/lack of behand the presence/lack of behand the presence of the medication of the facility failed to end to be a did to the presence of the medication of the medication of the physical behavioral so thers, wandered, and needed extensive as mobility/transfer/dressimonths prior to admission of the Care Area Assessibility facility failed to end to the physical behavioral so the physical behavioral so the physical behavioral so the physical behavioral so the care Area Assessibility facility failed to end to the physical behavioral so the care Area Assessibility facility failed to end to the physical behavioral so the care Area Assessibility facility failed to end to the physical behavioral so the care Area Assessibility facility failed to end to the physical behavioral so the care Area Assessibility facility failed to end to the physical behavioral so the care Area Assessibility failed to end to the physical behavioral so the care and the physical behavioral so the care and the physical behavioral so the phy	discrepancy consultant ted to the physician and the pregularities. 3/12 admission Minimum di the resident had mild en, disorganized thinking, ymptoms directed toward di intruded on others, sistance with bed ising/toileting, had a fall 2-6 esion, and had no restraints.	F 4	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/0	2/2012
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU			•	408	T ADDRESS, CITY, STATE, ZIP CODE DELAWARE STREET ICHESTER, KS 66097		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	The record lacked an Movement Scale (Alf The care plan dated resident had combating resident used both an tried to help him/her is building, The care plated dealt with depression anti-depressant) 20 in care plan recorded the of psychosis and reconstruction of psychosis and reconstruction and is a resident received Ola 5 mg as needed ever behaviors and listed the care plan record become quite agitate resident became angular the resident took Met. The care plan did not Warnings for Seroque Metformin. The behavior monitor 7/12 recorded the following ming at 3:00 P.M. and as needed. The Geriatric Dosage page 1509 recorded Warning/Precautions	y Abnormal Involuntary MS) assessment. 6/20/12 recorded the ve behaviors, and the rms to strike out at staff who remain safely inside the recorded the resident and received Celexa (an illigrams (mg) daily. The resident had a diagnosis eived Seroquel (an right at 3:00 P.M., and for the reverse side effects. The recorded (an anti-psychotic) by 4 hours for dementia with the potential side effects. The resident could do and the resid	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E294			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WIN	G		08/02/2012		
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU				40	EET ADDRESS, CITY, STATE, ZIP CODE 8 DELAWARE STREET INCHESTER, KS 66097	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	with antipsychotics and death compared to plapproved for treatme psychosis. The Geriatric Dosage page 1276 recorded Warning/Precautions patients with dementi with antipsychotics with death compared to ploto be either cardiovas In addition, an increa cerebrovascular effect. The Geriatric Dosage page 1101 recorded Warning/Precautions Lactic acidosis was a consequence of there. The monthly drug regidid not identify any in An observation on 7/3 resident sat in the whappeared to nap. An interview 7/3/12 a administrative staff B resident's behavior milisted the specific behavior drugs, which behavior drugs, which made it monitor the medication.	re at an increased risk of acebo. Quetiapine was not int of dementia related a Handbook, 16 th Edition, for Olanzapine: (U.S. Boxed Warning): a-related psychosis treated ere at an increased risk of acebo. Most deaths appear scular or infectious in nature. Sed incidence of ets has been reported. a Handbook, 16 th Edition, for Metformin: (U.S. Boxed Warning): rare, but potentially severe apy with Metformin. gimen review dated 7/20/12 regularities. 30/12 at 7:30 A.M. the eel chair by the aviary and	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E294		DENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING _		08/02/2012			
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU			s	TREET ADDRESS, CITY, STATE, ZIP CODE 408 DELAWARE STREET WINCHESTER, KS 66097			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	An interview 7/31/12 administrative nursing unaware that Seroque and reported the care resident's Black Box. An interview 8/1/12 aconsultant J said he/st resident's charts, more psychotropic medicated dose reduction, monitored for appropiconsultant DJ said the identifying Black Box he/she checked to see behavior monitoring state facility monitored. The facility consultant medication irregularity impaired, extensive assistance transfer, and received medication. The Care Area Assess 10/11/11 for mood state had a diagnosis of demilligrams (mg) daily	arding the behavior ecause had they he/she it. at 1:15 P.M. with g staff B said they were el had a Black Box Warning, e plan did not include this Warning medication. It 10:57 A.M. with pharmacy she reviewed monthly each nitored if residents were on tion and possibly needed a tored laboratory values, and riate diagnosis. The ey assisted the facility in Warning medications, ee if the facility completed the sheets but did not direct how medications and behaviors. It J failed to identify ies.	F 42	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
17E294		B. WING			08/02/2012		
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU				4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET WINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	often actually was. That times, but appeare time. The care plan dated resident had social is disease related demeloss, and had a histor depression/hallucinat staff for most activitie received Paxil for depobserve for changes document abnormal to the physician progre resident slept well, had reams, in no appareresting tremor. The monthly drug reg 6/18/12, 5/15/12, 4/16/1/18/12, and 12/15/1/1 reduction for Paxil. An observation on 7/2 resident sat in his/her napping. An interview 7/31/12 administrative staff B attempted a dose red resident had been on	ore depressed than he/she the resident became moody d stable on Paxil at this 10/31/10 indicated the colation due to Parkinson's entia and severe hearing by of ions/delusions, needed one s of daily living cares, oression, and for the staff to in mental status and behaviors every shift. The senteman service of the ad previously reported vivid and distress and with no The previous of the staff to in mental status and behaviors every shift. The service of the ad previously reported vivid and distress and with no The previous of the staff to in mental status and behaviors every shift. The service of the staff to in mental status and behaviors every shift. The service of the staff to in mental status and behaviors every shift. The staff to in mental status	F	428			
	consultant J said he/s resident's charts, mor	she reviewed monthly each nitored if residents were on ion and possibly needed a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
17E294		17E294	B. WING		08 /	08/02/2012	
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU				STREET ADDRESS, CITY, STAT 408 DELAWARE STREET WINCHESTER, KS 6609			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	monitored for approp consultant DJ said the identifying Black Box he/she checked to see behavior monitoring seems the facility monitored. The facility consultant medication irregularithal and the facility consultant medication. The Care Area Assess 6/5/12 for psychotrop resident was followed behavioral problems received Zyprexa (and dementia related behavio	tored laboratory values, and riate diagnosis. The ey assisted the facility in Warning medications, e if the facility completed the sheets but did not direct how medications and behaviors. It J failed to identify es. Ual Minimum Data Set 3.0 dthe resident was activities of daily living, and ic and an anti-depressant esment worksheet date ic medication recorded the laby a psychiatrist for the medication management, ti-psychotic) medication for aviors, and Remeron for solventy and the est sad/anxious, hoarding, easily believed others were build get upset and try to times I threaten others when male residents" and for the appointments with the am upset because I think hing from me, listen to me	F 4	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		17E294	B. WIN	G		08/02	2/2012
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU				4	REET ADDRESS, CITY, STATE, ZIP CODE 108 DELAWARE STREET VINCHESTER, KS 66097		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	female residents" The monthly drug reg 6/18/12, 5/15/12, 4/16 1/18/12, and 12/15/11 irregularities. The behavior sheet dethe following behavior delusions/paranoia/refollowing medications and Remeron 30 mg. An observation on 7/3 resident sat in his/her room, waiting to go of the following sheets the behaviors the staff modifferent drugs, Zypre Remeron (an anti-dep which behaviors relatively medications for effications and the following monitoring sheets the behaviors the staff modifferent drugs, Zypre Remeron (an anti-dep which behaviors relatively medications for effications for effications and the following monitored for appropic consultant J said he/s resident's charts, mor psychotropic medications for effications for	imen review dated 7/20/12, 8/12, 3/7/12, 2/15/12, 1 did not identify any ated 6/12 and 7/12 recorded rs: fusal of cares, and the : Zyprexa 2.5 milligram (mg) at on an outing. 2.15 A.M. with administrative the resident's behavior facility listed the specific ponitored, and listed 2 axa (an anti-anxiety) and pressant) but did not specify ed to which of the drugs, for the staff to monitor the cy. 2.10:57 A.M. with pharmacy the reviewed monthly each photographic formulation of the drugs, and pressed if residents were on and possibly needed a pored laboratory values, and riate diagnosis. The reassisted the facility in	F	428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E294	B. WING			09/02/2042		
	ROVIDER OR SUPPLIER			408	ET ADDRESS, CITY, STATE, ZIP CODE B DELAWARE STREET NCHESTER, KS 66097	08/02/2012 CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 428	Continued From page the facility monitored The facility consulta	d medications and behaviors.	F	428				
F 467 SS=E	medication irregular 483.70(h)(2) ADEQUENTILATION-WIN The facility must have ventilation by means ventilation, or a com	JATE OUTSIDE DOW/MECHANIC ve adequate outside s of windows, or mechanical	F	467				
	by: The facility identifie Based on observation interview the facility	T is not met as evidenced d a census of 25 residents. on, record review, and staff failed to maintain adequate the personal care room for site of the survey.						
	approximately 2:00 maintenance staff H personal care room any means of outsid ventilation. The roor	ntal tour on 7/26/12 at P.M. to 2:35 P.M. with , observation identified the (beauty shop) did not have e mechanical or window n lacked an exhaust vent and dows which opened to the						
	approximately 2:20	aintenance staff H at P.M. on 7/26/12, revealed the lacked any means of						
	The facility failed to ventilation in the per	have a policy for adequate sonal care room.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
17E29 4		B. WING		08/0	2/2012		
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY MEM HOSPITAL LTCU			S	STREET ADDRESS, CITY, STATE, ZIP COI 408 DELAWARE STREET WINCHESTER, KS 66097	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 467	Continued From page The facility failed to n for the personal care	naintain adequate ventilation	F 46	67			